



VISION BENEFITS ENROLLMENT / CHANGE FORM

State Form 50678 (R / 2-02)

Return this form to the Human Resource Department or Payroll Personnel in your agency. Please print.

Employee Name _____

SS# _____

Agency _____

Hire Date _____

ENROLLMENT

_____ I would like to enroll in the Vision Program:

____Employee Only

____Employee and Family

_____ I decline coverage at this time.

Dependents: Name

Date of Birth

Relationship

Spouse _____

CHANGE OF COVERAGE

_____ I would like to change my coverage from:

____Single to Family

Add the following Dependents:

Date of Birth

Relationship

Spouse _____

_____ I would like to change my coverage from:

____Family to Single

Delete the following Dependents:

Signature

Date

Agency: Keep this for internal records. Do not forward to the Vision Carrier.